

SEP 10 1943

Registration District No. 310

Primary Registration District No. 6051

1. PLACE OF DEATH:

(a) County St. Charles
 (b) City or town Jefferson
 (c) Name of hospital or institution:
County Farm 5
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 3 Years
 In this community Life
 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St. Charls
 (c) City or town _____
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____
 (If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Nettie Kellar

3. (b) If veteran, name war _____ 3. (c) Social Security No. None

4. Sex FF F 5. Color or race W 6. (a) Single, widowed, married, divorced 0

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased March 14 1871
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
72 5 10 _____ hr. _____ min.

9. Birthplace St. Charles Co (City, town, or county) (State or foreign country)

10. Usual occupation House work

11. Industry or business _____

MOTHER FATHER { 12. Name George Keller
 13. Birthplace Virginia (City, town, or county) (State or foreign country)

{ 14. Maiden name Martha Bacon
 15. Birthplace St. Louis Co (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. C. E. Fudley
 (b) Address Flint Hill Mo

17. (a) Burial (b) Date thereof Aug. 25, 1943
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Defiance

18. (a) Signature of funeral director Marion Muehary
 (b) Address Wentzville

19. (a) 8-25-1943 (b) Carroll L. Paul
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 24 year 1943 hour 8:00 minute 10 P.M.

21. I hereby certify that I attended the deceased from Aug 6 1943 to Aug 24 1943 that I last saw her alive on Aug 23 1943 and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to Uraemia
Chronic Nephritis
Gen Arterio sclerosis

Other conditions no
 (Include pregnancy within 3 months of death)

Major findings: Of operations no

Of autopsy no

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____ (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature A. P. Erick Schuch M.D. of other _____
 Address St. Charles Mo Date signed 8/25/43

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....
Marvin Munkberg

Licensed Embalmer No... 3461

P. O. Address. Wentzville, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 310

Primary Registration District No. 6051

Registrar's No.

1. PLACE OF DEATH:

(a) County St. Charles
(b) City or town _____
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution County Farm
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
in this community _____ years, months or days)

3. (a) PRINT FULL NAME Nettie Kellar

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ year

7. Birth date of deceased Mar 14
(Month) (Day) (Year)

8. AGE: Years 72 Months _____ Days _____ If less than one day _____ min.

9. Birthplace _____ (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (Burial, cremation, or removal) (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation Refugee Md

18. (a) Signature of funeral director Morris M. M. M. M.

(b) Address Wentzville Mo

19. (a) _____ (Date received local registrar) (b) Levi L. Paulk (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May Day 24 Year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____; that I last saw him/her alive on _____ 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

29193